cost basis for anesthesia services provided in a hospital by qualified nonphysician anesthetists employed by the hospital or obtained under arrangement, if the hospital demonstrates to its intermediary prior to April 1, 1989 that it meets the following criteria:

(A) The hospital is located in a rural area as defined in §412.62(f) and is not deemed to be located in an urban area under the provisions of §412.64(b)(3).

(B) The hospital must have employed or contracted with a qualified nonphysician anesthetist, as defined in §410.66 of this chapter, as of January 1, 1988 to perform anesthesia services in that hospital. The hospital may employ or contract with more than one anesthetist; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.

(C) The hospital must provide data for its entire patient population to demonstrate that, during calendar year 1987, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 250 procedures. For purposes of this section, a *surgical procedure requiring anesthesia services* means a surgical procedure in which the anesthesia is administered and monitored by a qualified nonphysician anesthetist, a physician other than the primary surgeon, or an intern or resident.

(D) Each qualified nonphysician anesthetist employed by or under contract with the hospital has agreed in writing not to bill on a reasonable charge basis for his or her patient care in that hospital.

(ii) To maintain its eligibility for reasonable cost payment under paragraph (c)(2)(i) of this section in calendar years after 1989, a qualified hospital must demonstrate prior to January 1 of each respective year that for the prior year its volume of surgical procedures requiring anesthesia service did not exceed 500 procedures.

(iii) A hospital that did not qualify for reasonable cost payment for nonphysician anesthetist services furnished in calendar year 1989 can qualify for reasonable cost payment in subsequent calendar years, if it meets the criteria in §412.113(c)(2)(i) (A), (B) and (D) above, and demonstrates to its intermediary prior to the start of the calendar year that it met these criteria. The hospital must provide data for its entire patient population to demonstrate that, during calendar year 1987 and the year immediately preceding its election of reasonable cost payment, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures.

(iv) For administrative purposes for the calendar years after 1990, the volume of surgical procedures for the immediately preceding year is the sum of the surgical procedures for the nine month period ending September 30, annualized for the twelve month period.

(d) *Heart, kidney, liver, and lung acquisition costs incurred by hospitals with approved transplantation centers.* Payment for heart, kidney, liver, and lung acquisition costs incurred by hospitals with approved transplantation centers is made on a reasonable cost basis.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §412.113, see the List of CFR Sections Affected in the Finding Aids section of this volume.

§412.115 Additional payments.

(a) *Bad debts.* An additional payment is made to each hospital in accordance with §413.80 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.

(b) *Administration of blood clotting factor.* For discharges on or after June 19, 1990, and before October 1, 1994, an additional payment is made to a hospital for each unit of blood clotting factor furnished to a Medicare inpatient who is hemophiliac.

(c) *PRO photocopy and mailing costs.* An additional payment is made to a hospital in accordance with §466.78 of this chapter for the costs of photocopying and mailing medical records requested by a PRO.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 55 FR 15175, Apr. 20, 1990; 56 FR 43448, Aug. 30, 1991; 57 FR 39825, Sept. 1, 1992; 57 FR 47787, Oct. 20, 1992; 58 FR 46339, Sept. 1, 1993]

§ 412.116 Method of payment.

(a) *General rule.* Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services furnished by an excluded psychiatric or a rehabilitation unit of a hospital are made as described in § 413.64 (a), (c), (d), and (e) of this chapter.

(b) *Periodic interim payments*—(1) *Criteria for receiving periodic interim payments.* Effective with claims received on or after July 1, 1987, a hospital that meets the criteria in § 413.64(h) of this chapter may request in writing to receive periodic interim payments as described in this paragraph. A hospital that is receiving periodic interim payments also receives payment on this basis for inpatient hospital services furnished by its excluded psychiatric or rehabilitation unit.

(i) *Failure of intermediary to make prompt payment.* Beginning with claims received in April 1987, the hospital's fiscal intermediary does not meet the requirements of section 1816(c)(2) of the Act, which provides for prompt payment of claims under Medicare Part A, for three consecutive calendar months. The hospital may continue to receive periodic interim payments until the intermediary meets the requirements of section 1816 (c)(2) of the Act for three consecutive calendar months. For purposes of this paragraph, a hospital that is receiving periodic interim payments as of June 30, 1987 and meets the requirements of § 413.64(h) of this chapter may continue to receive payment on this basis until the hospital's intermediary meets the requirements of section 1816(c)(2) of the Act for three consecutive calendar months beginning with April 1987.

(ii) *Hospitals that serve a disproportionate share of low-income patients.* The hospital is receiving periodic interim payments as of June 30, 1987 and has a disproportionate share payment adjustment factor of at least 5.1 percent as determined under § 412.106(c) for purposes of establishing the average standardized amounts for discharges occurring on or after October 1, 1986 and before October 1, 1987. The hospital's request must be made by a date prior to July 1, 1987, specified by the intermediary.

(iii) *Small rural hospitals.* The hospital is receiving periodic interim payments as of June 30, 1987, makes its request by a date prior to July 1, 1987, specified by the intermediary, and, on July 1, 1987, the hospital—

(A) Is located in a rural area as defined in § 412.62(f); and

(B) Has 100 or fewer beds available for use.

(2) *Frequency of payment.* The intermediary estimates a hospital's prospective payments as described in paragraph (b)(3) of this section and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. Each payment is made two weeks after the end of a biweekly period of service, as described in § 413.64(h)(5) of this chapter. These payments are subject to final settlement.

(3) *Amount of payment.* (i) The biweekly interim payment amount is based on the total estimated Medicare discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount as described in paragraph (b)(3)(ii) of this paragraph. These interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a hospital receives interim payments for less than a full reporting period.

(ii) For purposes of determining periodic interim payments under this paragraph, a hospital's estimated average prospective payment amount is computed as follows:

(A) If a hospital has no payment experience under the prospective payment system for operating costs, the intermediary computes the hospital's estimated average prospective payment amount for operating costs by multiplying its payment rates as determined under § 412.70(c), but without adjustment by a DRG weighting factor, by the hospital's case-mix index, and subtracting from this amount estimated deductibles and coinsurance.

(B) Effective for cost-reporting periods beginning on or after October 1,